

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013610

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

3198

STATE FILE NUMBER

FILED MAR 28 1963

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis | | c. CITY OR TOWN Summerfield | |
| Length of stay in 1b 10 days | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke Hosp. | | d. STREET ADDRESS (If outside, give location) none | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Cornelia Middle Monken Last Monken | | 4. DATE OF DEATH Month March Day 18 Year 1963 | |
| 5. SEX female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3/18/90 |
| 9. AGE (last birthday) 73 | | IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73 | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) household | | 11. BIRTHPLACE (City and state or country) St. Clair County, Ill. | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME Phillip Perschbacher | |
| 13b. MOTHER'S MAIDEN NAME Rose Phoetner | | 14. NAME OF HUSBAND OR WIFE Joseph V. Monken | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 17. INFORMANT Joseph V. Monken | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage Subarachnoid Spont. DUE TO (b) Aneurysm, int. carotid - not verified DUE TO (c) Arteriosclerosis cerebrovascular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pneumonia, terminal | | INTERVAL BETWEEN ONSET AND DEATH 10 days year | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | 20c. TIME OF INJURY Hour 4:51 a.m. 4:51 p.m. | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION St. Clair County, Illinois | | 20g. STATE Illinois | |
| 21. I attended the deceased from 3-10-63 to 3-18-63 and last saw her alive on 3-17-63 Death occurred at 6:50 A.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE George E. Perschbacher M.D. | | 22b. ADDRESS 3720 Washington Ave St. Louis | |
| 22c. DATE SIGNED 3-19-63 | | 22d. SIGNATURE Lois Smith M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 3/18/63 | |
| 23c. NAME OF CEMETERY OR CREMATORY Summerfield | | 23d. LOCATION (City, town, or county) St. Clair County, Illinois | |
| 24. FUNERAL DIRECTOR L.M. Wolfersberger | | 25. DATE RECD. BY LOCAL REG. MAR 19 1963 | |

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300
Rev. 4/59

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28/20, 7

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Frank Prohaff

Licensed Embalmer No. 4356

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.